(MEI) and reflects the relationship between the relative value units for the professional and technical components of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(c) *Professional component billing representing only the physician's interpretation for the procedure.* If the professional component of screening mammography services is billed separately, the amount of payment for that professional component, subject to the deductible, is equal to 80 percent of the least of the following:

(1) The actual charge for the professional component of the service.

(2) The amount established for the professional component of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(3) The professional component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

(d) *Technical component billing representing other resources involved in furnishing the procedure.* If the technical component of screening mammography services is billed separately, the amount of payment, subject to the deductible, is equal to 80 percent of the least of the following:

(1) The actual charge for the technical component of the service.

(2) The amount established for the technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(3) The technical component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

[55 FR 53521, Dec. 31, 1990, as amended at 59 FR 49833, Sept. 30, 1994; 66 FR 55328, Nov. 1, 2001]

§405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are physician services pursuant to §414.2 of this chapter paid under the physician fee schedule. If screening mammography services are furnished to a beneficiary by a nonparticipating physician or supplier that does not accept assignment, a limiting charge applies to the charges billed to the beneficiary. The limiting charge is the lesser of the following:

(a) 115 percent of the payment limit set forth in §405.534(b)(3), (c)(3), and (d)(3) (limitations on the global service, professional component, and technical component of screening mammography services, respectively).

(b) The limiting charge for the global service, professional component, and technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services set forth at §414.48(b) of this chapter.

[59 FR 49833, Sept. 30, 1994, as amended at 62 FR 59098, Oct. 31, 1997; 66 FR 55328, Nov. 1, 2001]

Subpart F [Reserved]

Subpart G—Reconsiderations and Appeals Under Medicare Part A

AUTHORITY: Secs. 1102, 1155, 1869(b), 1871, 1872, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c–4, 1395ff(b), 1395hh, 1395ii, and 1395pp).

SOURCE: 37 FR 5814, Mar. 22, 1972, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§405.701 Basis, purpose and definitions.

(a) This subpart implements section 1869 of the Social Security Act. Section 1869(a) provides that the Secretary will make determinations about the following matters, and section 1869(b) provides for a hearing for an individual who is dissatisfied with the Secretary's determination as to:

(1) Whether the individual is entitled to hospital insurance (part A) or supplementary medical insurance (part B) under title XVIII of the Act; or

(2) The amount payable under hospital insurance.

(b) This subpart establishes the procedures governing initial determinations, reconsidered determinations, hearings, and final agency review, and the reopening of determinations and

decisions that are applicable to matters arising under paragraph (a) of this section.

(c) Subparts J and R of 20 CFR part 404 (dealing with determinations, the administrative review process and representation of parties) are also applicable to matters arising under paragraph (a) of this section, except to the extent that specific provisions are contained in this subpart.

(d) *Definitions.* As used in subpart G of this part, the term—

Appellant designates the beneficiary, provider or other person or entity that has filed an appeal concerning a particular determination of benefits under Medicare part A. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Common issues of law and fact, with respect to the aggregation of claims by two or more appellants to meet the minimum amount in controversy needed for a hearing, occurs when the claims sought to be aggregated are denied or reduced for similar reasons and arise from a similar fact pattern material to the reason the claims are denied.

Delivery of similar or related services, with respect to the aggregation of claims by two or more provider appellants to meet the minimum amount in controversy needed for a hearing, means like or coordinated services or items provided to the same beneficiary by the appellants.

[55 FR 11020, Mar. 26, 1990, as amended at 59 FR 12181, Mar. 16, 1994]

§ 405.702 Notice of initial determination.

After a request for payment under part A of title XVIII of the Act is filed with the intermediary by or on behalf of the individual who received inpatient hospital services, extended care services, or home health services, and the intermediary has ascertained whether the items and services furnished are covered under part A of title XVIII, and where appropriate, ascertained and made payment of amounts due or has ascertained that no payments were due, the individual will be notified in writing of the initial determination in his case. In addition, if the items or services furnished such individual are not covered under part A of title XVIII by reason of § 411.15(g) or § 411.15(k) and payment may not be made for such items or services under § 411.400 only because the requirements of § 411.400(a)(2) are not met, the provider of services which furnished such items or services will be notified in writing of the initial determination in such individual's case. These notices shall be mailed to the individual and the provider of services at their last known addresses and shall state in detail the basis for the determination. Such written notices shall also inform the individual and the provider of services of their right to reconsideration of the determination if they are dissatisfied with the determination.

[55 FR 11020, Mar. 26, 1990]

§ 405.704 Actions which are initial determinations.

(a) *Applications and entitlement of individuals.* An initial determination with respect to an individual includes the following—

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance;

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA will specify in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence);

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance;

(4) A denial of a request for cancellation of a ''request for withdrawal''; and

(5) A determination as to whether an individual, previously determined to be entitled to hospital or supplementary medical insurance, is no longer entitled to such benefits, including a determination based on nonpayment of premiums.

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under